



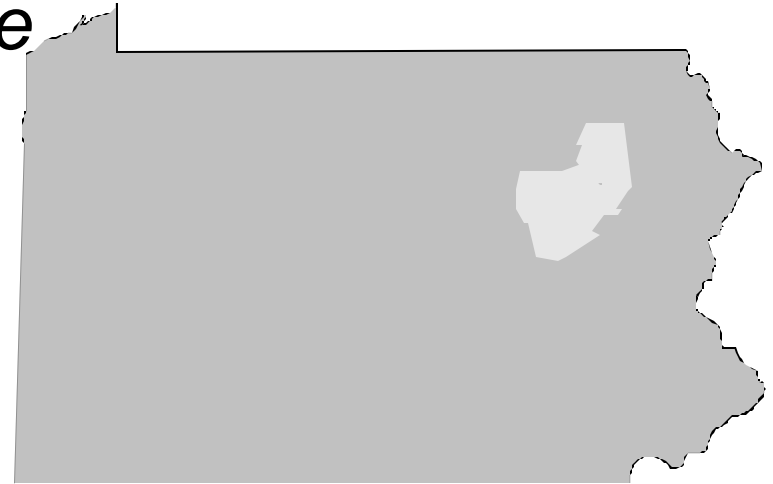
# Healthy Northeast Access Program

*The University of Scranton  
Center for Public Initiatives  
Lisa Baumann, MHA*



## Northeast Pennsylvania

- Primary Service Area
  - *Scranton/Wilkes-Barre*
- Population - 500,000
  - *Region = 1 million*
- Uninsured - 55,000  
Medicaid - 50,000  
Medicare - 100,000 (high morbidity)
- Small Employer Area





## **Northeast PA Community Need**

- Economically depressed area - 40% of population on edge of poverty.
- High elderly population.
- 23% inability to pay for physician visit.
- 55,000 uninsured - 15,000 seeking care.
- Inappropriate use of emergency department.
- Poor health choices - sedentary life style.
- Issues with dental services/pharmaceuticals.



## Major Themes of the Project

- Expanding access through core and referral partners
- Creating a comprehensive system of care
- Coordinated Care
- Maximizing Existing Resources
  - 100% Access, 0% Disparity



# Core Partners and Referral Partners



## Core Partners – Primary Care

1. Scranton Primary Health Care - FQHC
2. Rural Health Corporation of  
Northeastern Pennsylvania - FQHC
3. Scranton-Temple Health Center
4. Wyoming Valley Family Practice  
Residency Program



## Referral Partners

55 Signed Memorandum of  
Understanding with Community  
Organizations

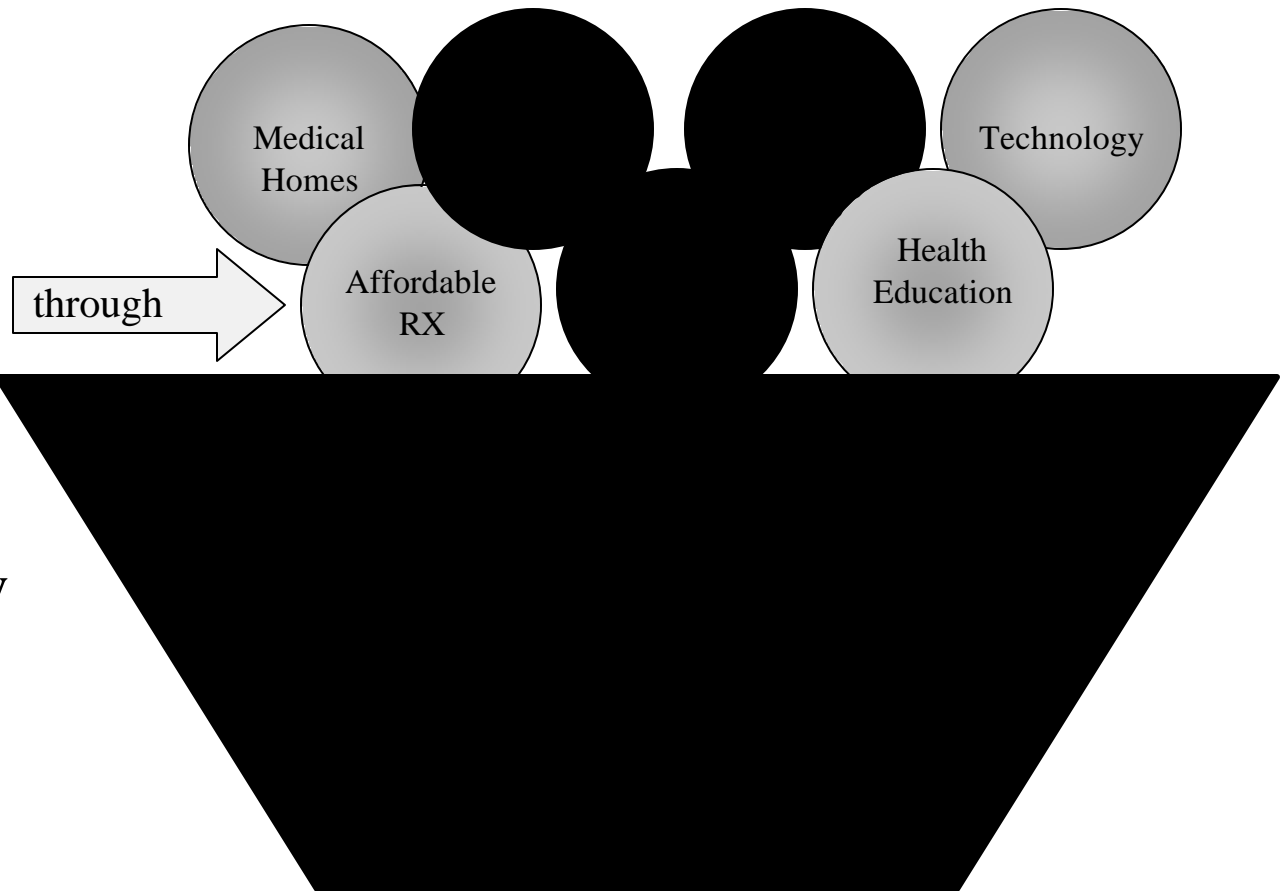


## **Project Objectives**

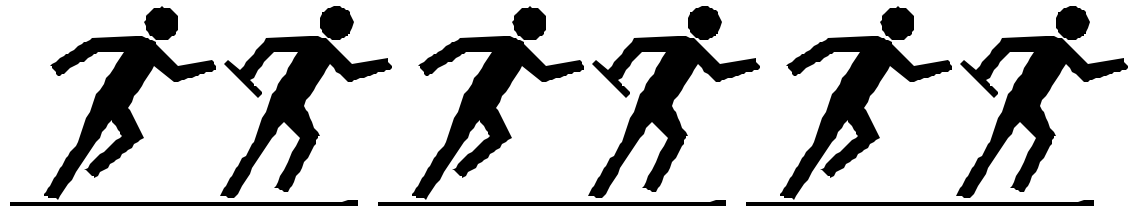
- Develop outreach strategies for the uninsured and underinsured population of NEPA;
- Use electronic technology to improve care coordination between core and referral partners of the Healthy Northeast Access Program;
- Improve the health status of citizens of Northeastern Pennsylvania through optimal use of community resources;
- Increase access to dental services; and
- Increase availability of pharmaceutical products.

*Better Health*

through



*At Less Cost by*





# What Data do we Need?

Begin with the End in Mind.....

- What is it we need to capture for HRSA reporting requirements?
- What other outcomes would we like to capture for collaborative members, other funding sources, media, etc.
- How can we build a new data system to capture this information?
- How can we adapt our current system?
- How do we make modifications if/when the reporting requirements change?



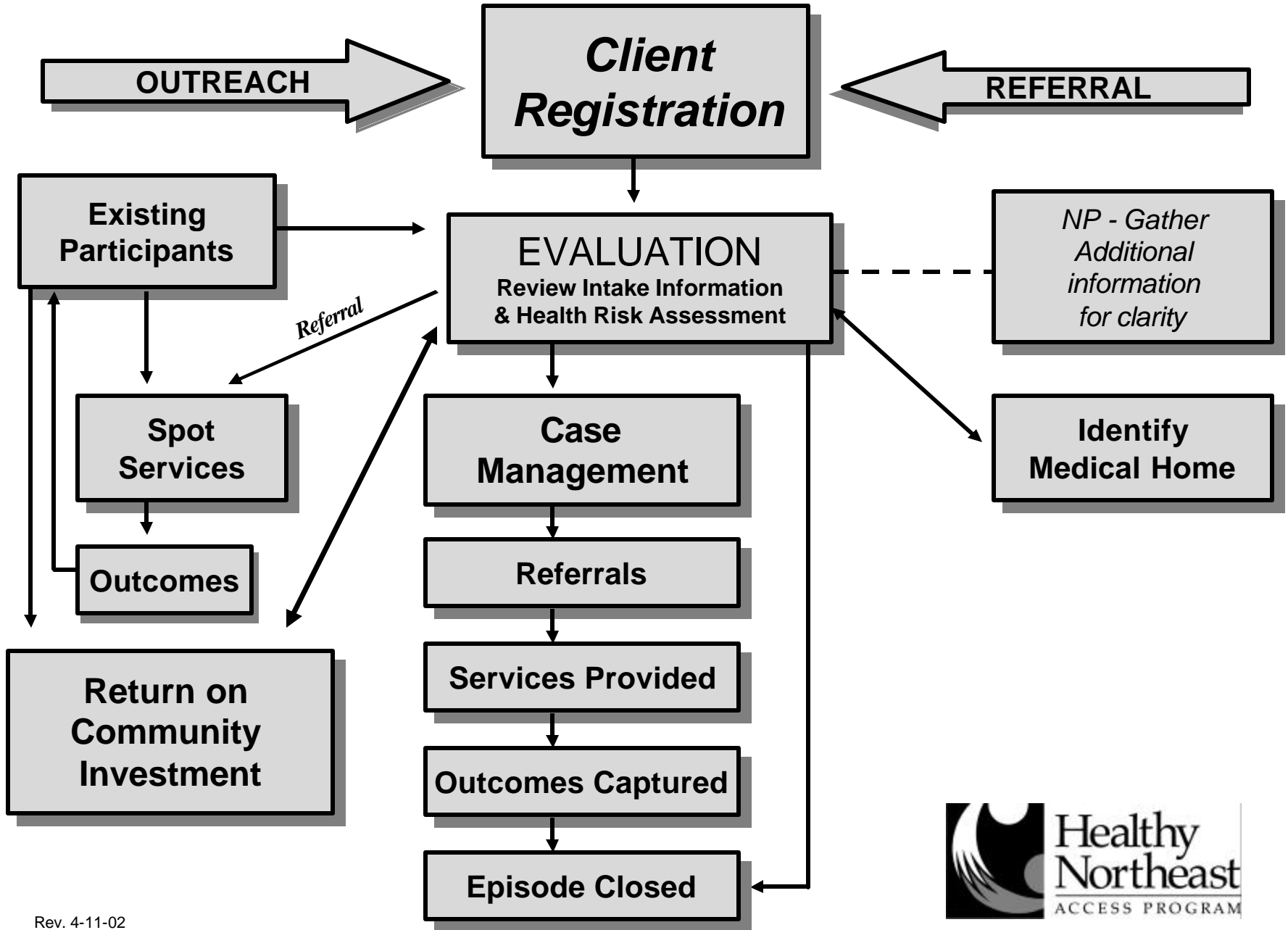


# Designing the Model

What's needed for effective care coordination:

- A comprehensive view of the client
- A way in which to focus on highest need/risk
- Community resources at your fingertips
- The ability to easily assign, capture and follow up on referrals to outside providers and agencies
- Information sharing with partners

### Care Coordination Model



# Gathering the Output Data



## Care Coordination Information System

SiteCode: HNAP

Current User: amulrine

Organizations

Find organizations and agencies.

Services Query Tool

Search for organizations and agencies by category, county, service type, keyword, etc.

HNAP Client List

Access the list of clients including their demographics, HRA's, appointments, etc.

Client Search

Search for clients.

CC/CM Client List

Access Case Management and Care Plans.

Meds

Search for Medications by category or brand name, including costs & recommended dosages.

O and E Events

Add or view Outreach and Education Events.

Reports

Select from a list of standard reports to view and/or print.

System Maint

Add selections to pick lists.

Eligibility Tool

Enter client information and determine eligibility for programs and services.

Developed for HNAP by the Royal Technology Group - 570.941.4123 ©2003 The University of Scranton

Exit

# Finding the Resources

Organization Name: <input type="text" value="Aging Department of Pennsylvania"/>		<input type="button" value="Preview Report"/>	<input type="button" value="Close"/>																												
Facility   Programs & Keywords   Languages   Insurance / County / Categories																															
<b>Web URL:</b> <input type="text" value="http://www.aging.state.pa.us"/>		<b>Address:</b> <input type="text" value="555 Walnut Street"/> <input type="text" value="Forum Place"/> <b>City, St, Zip:</b> <input type="text" value="Harrisburg"/> <input type="text" value="PA"/> <input type="text" value="17120"/>																													
<b>Notes:</b> The State Area Office on Aging Oversees all of the programs and services that are available to our elderly population.		<b>Parking Available?</b> <input type="text" value="Yes"/> <b>Handicap Accessible?</b> <input type="text" value="Yes"/>																													
<input checked="" type="checkbox"/> <b>Ck if this is a Parent Organization</b> <b>If not a parent org, select parent from list:</b> <input type="text"/>		<b>Organization Contacts:</b>																													
		<table border="1"><thead><tr><th>First</th><th>Last</th><th>Title</th><th>Dept</th><th>Phone</th></tr></thead><tbody><tr><td>Nora Dowd</td><td>Eisenhower</td><td>Secretary</td><td>PA. Dept. of Aging</td><td>(800) 992-2433</td></tr><tr><td colspan="5"><b>Email</b> <input type="text"/></td></tr></tbody></table>		First	Last	Title	Dept	Phone	Nora Dowd	Eisenhower	Secretary	PA. Dept. of Aging	(800) 992-2433	<b>Email</b> <input type="text"/>																	
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<b>Last Updated:</b> <input type="text" value="4/15/2003"/>		<b>Information Verified &amp; Complete?</b> <input checked="" type="checkbox"/>																													

# Organizing the Data

Access, N.E			Staff: Noone	Close Form	
Demographic Data	Care Plan	HRA for Access, N.E	Key Questions	6 Month FollowUp	Client Info
Date: 10/2/2003	Follow Up Date: 10/4/2003	Date Follow Up Completed:	Time Spent: 0.75 hours		
Event Short Desc: Contact		Event Type: Case Management	Interaction? <input checked="" type="checkbox"/>		
<p>Client verbalizes understanding of consents and authorizations. Client is under a great deal of stress, she is a single parent with 2 children. She is divorced and reports that the father of her children is only limitedly involved in their care. She is frustrated with the financial pressures and trying to raise 2 children by herself. She does report using smoking as a coping mechanism, she was educated re the hazards of smoking &amp; the correlation with asthma. She is not ready to quit at this time but is contemplating quitting. She reports mild pain as 5 on a scale of 0 to 10. Diet is high in fat and she has gained 15 pounds in the last year and does not exercise due to poor stamina. She will discuss this with her medical provider. She is at risk for breast cancer secondary to family history, first degree relative, high fat diet and lack of exercise, smoking &amp; stress. She states "my mother was</p>					
<b>Subject Checklist - check each topic covered</b>					
<input checked="" type="checkbox"/> Self Care	<input checked="" type="checkbox"/> Healthy Behavior	<div>This Info was given to:</div> <div><input type="checkbox"/> Care Giver</div> <div><input checked="" type="checkbox"/> Client</div>			
<input checked="" type="checkbox"/> Navigation of Health System	<input checked="" type="checkbox"/> Consents & Auth				
<input checked="" type="checkbox"/> Disease Detection	<input checked="" type="checkbox"/> Handbook/Welcoming Kit				
<input checked="" type="checkbox"/> Availability of Public Insurance	<input checked="" type="checkbox"/> Key Questions				
<input checked="" type="checkbox"/> Appropriate use of ED	<input checked="" type="checkbox"/> Primary Care Physician				
<input checked="" type="checkbox"/> Finding a Medical Home	<input checked="" type="checkbox"/> Dentist				
<b>REFERRALS</b>					
Type of Referral: Facility Referred to: Search for Facility					
Medical Home Medical Home Now					
Name of person to contact:					
Interpreter Needed? <input type="checkbox"/> Language:					
Follow Up Date: Follow Up Done? <input type="checkbox"/>					
Outcome: Number:					
Important Info: Client to make appointments & notify HNAP CM					
Dental Scranton Primary Health Care Center					
Name of person to contact:					
Interpreter Needed? <input type="checkbox"/> Language:					
Record: 2 of 5					

# Sharing the Data

Access, N.E				Close
Visit Date:	Complaint:	Provider's Name:	Data Entered By:	
10/6/2003	Difficulty Breathing	I.M.Algood CRNP	ellen	
<b>Height / Weight / Body Mass Index:</b>		<b>ICD9 Diagnosis:</b>		
Ht (Ft):	5	Ht (Inch):	3	493.21 - CH OB ASTHMA W STAT ASTH
Weight (Lbs):	145	BMI:	26	V790 - SCREENING FOR DEPRESSION
<input checked="" type="checkbox"/> Ck indicates this is the client's first visit		<input type="button" value="ICD9 Search"/>		
		<input type="button" value="Refresh"/>		
<b>Areas of Need:</b>				
<input checked="" type="checkbox"/> Care Access (Health Ins, Community resources, etc.)	<input type="checkbox"/> Functional (Physical disabilities)	<input checked="" type="checkbox"/> Personal (employment, financial, etc)		
<input checked="" type="checkbox"/> Emotional/Psychosocial	<input checked="" type="checkbox"/> Medications (Drug assistance, education, etc.)	<input checked="" type="checkbox"/> Preventive (screening, etc)		
<input type="checkbox"/> Environmental (Safety, housing, etc.)	<input checked="" type="checkbox"/> Nutrition (Diet, weight, etc.)	<input type="checkbox"/> Spirituality		
<b>Plan/Notes:</b>				
Please elaborate on areas of need. Double click for larger note area.		Client is in need of case management re stressful family situation, access to medical services, medical, dental ,prescriptions. She reports having difficulty coping, angry, anxious & frustrated. High fat diet with 15 lb weight gain in 6 months.		

# Evaluating the Progress

Select a Client:	<input type="text" value="Access, N.E"/>	<input type="button" value="Add to Care Plan (NANDA/NIC/NOC Menu)"/>	<input type="button" value="Print Care Plan"/>	<input type="button" value="Refresh"/>	<input type="button" value="Close Form"/>
Select a Diagnosis to view Care Plan activities:	<input type="text" value="Individual Coping, Ineffective"/>	<input type="button" value="View and Prioritize NANDA"/>			
<b>Client Interventions and Outcomes (NIC and NOC):</b>					
<b>Intervention Label and Definition (NIC)</b>					
Coping Enhancement					
Assisting a patient to adapt to perceived stressors, changes, or threats which interfere with meeting life demands and roles					
<b>Priority:</b>					
<input type="text" value="1"/>					
<b>% Complete:</b>					
<input type="text" value="25"/>					
<b>Outcome Label and Definition (NOC)</b>					
Coping					
Actions to manage stressors that tax an individual's resources					
<b>Personalize this Outcome:</b>					
<input type="text" value="Outcome personalization"/>					
<b>Personalize NIC Activities (double click for larger view):</b>					
<input type="text" value="Assist the patient in examining available resources to meet the goals"/>					
<b>Initials (Dbl click)</b> <input type="text" value="MEA"/> <b>Date Begin:</b> <input type="text" value="10/6/2003"/> <b>Date End:</b> <input type="text" value=""/> <b>Priority:</b> <input type="text" value="1"/>					
<input type="text" value="Encourage the patient to identify own strengths and abilities"/>					
<b>Initials (Dbl click)</b> <input type="text" value="MEA"/> <b>Date Begin:</b> <input type="text" value="10/6/2003"/> <b>Date End:</b> <input type="text" value=""/> <b>Priority:</b> <input type="text" value="2"/>					
Record: <input type="button" value="Previous"/> <input type="button" value="First"/> <input type="text" value="1"/> <input type="button" value="Next"/> <input type="button" value="Last"/> of 1					

# Reporting the Data

**Client Summary for:** Access, N.E

Client Demographics	HRA	Meds	Close Form
Care Plan Report	Care Plan	Reminders	

Sort Order ☒ Ascending ☐ Descending

Double Click on the Date to view the entry's details

Click to sort -->

Date	Type	Description
*****		
10/2/2003	Referral	Pennsylvania Department of Health, Quit Line
10/2/2003	Referral	Catholic Social Services of Lackawanna County
10/2/2003	Referral	Lackawanna County Assistance Office
10/2/2003	Referral	Scranton Primary Health Care Center
10/2/2003	Referral	Medical Home Now
10/2/2003	Appointment	Appointment Kept
10/2/2003	CM Event	Contact
10/6/2003	Office Visit	ICD9: V790 - SCREENING FOR DEPRESSION
10/6/2003	Office Visit	ICD9: 493.21 - CH OB ASTHMA W STAT ASTH
10/7/2003	CM Event	contact

Record: 1 of 10





## Feedback to Stakeholders

- Return on Community Investment

Program Outcomes must show:

- ✓ Benefit
  - ✓ Value
  - ✓ Savings
- Interventions must be defined and “costed out”
  - Outcomes must be linked to dollar values



# Return on Community Investment

INTERVENTION	TYPES OF BENEFIT, VALUE, SAVING	BENEFIT, VALUE, SAVINGS	MEASURE-MENT OF COSTS	SAVINGS-BENEFITS per 100 enrolled clients per year
Assuring enrollee has permanent medical home (primary care)	Avoided ED Visits for all enrollees	Savings = 37% less likely to have nonurgent ED visit (Petersen et al. 1998) 'Nonurgent Emergency Department Visits – The Effect of Having a Regular Doctor.' <i>Medical Care</i> 36(8):1249-55.	Savings = cost per ED visit \$600 x .37 fewer visits = \$222	<b>Savings \$22,000 per 100/yr</b>
Enrollment of uninsured person into permanent health insurance	Improved annual job earnings	Benefit = Annual earnings increase 10-30% (Kaiser 2002). Sicker and Poorer: The Consequences of Being Uninsured.	Earnings = 20% increase in average salary of \$25,000	<b>Benefit \$500,000 additional earnings per100/yr</b>
Teaching health related self-management skills	Avoided hospitalizations and days for all enrollees	Savings = \$750/yr (fewer hospitalizations) (Lorig et al. 1999) 'Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization'. <i>Medical Care</i> 37(1): 5-14.	Savings = \$750 x number of clients receiving self-management skills	<b>Savings \$75,000 per 100/yr</b>

*Better Health*

through

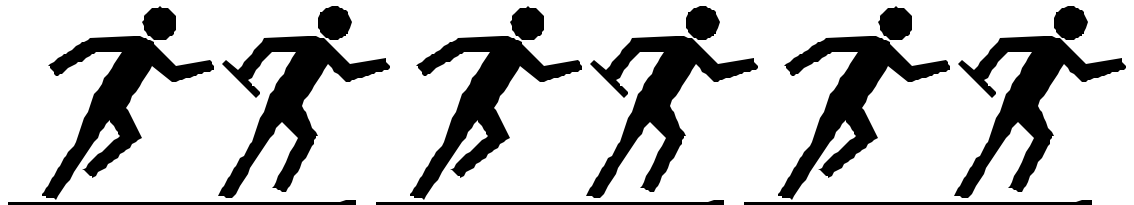
Medical  
Homes

Affordable  
RX

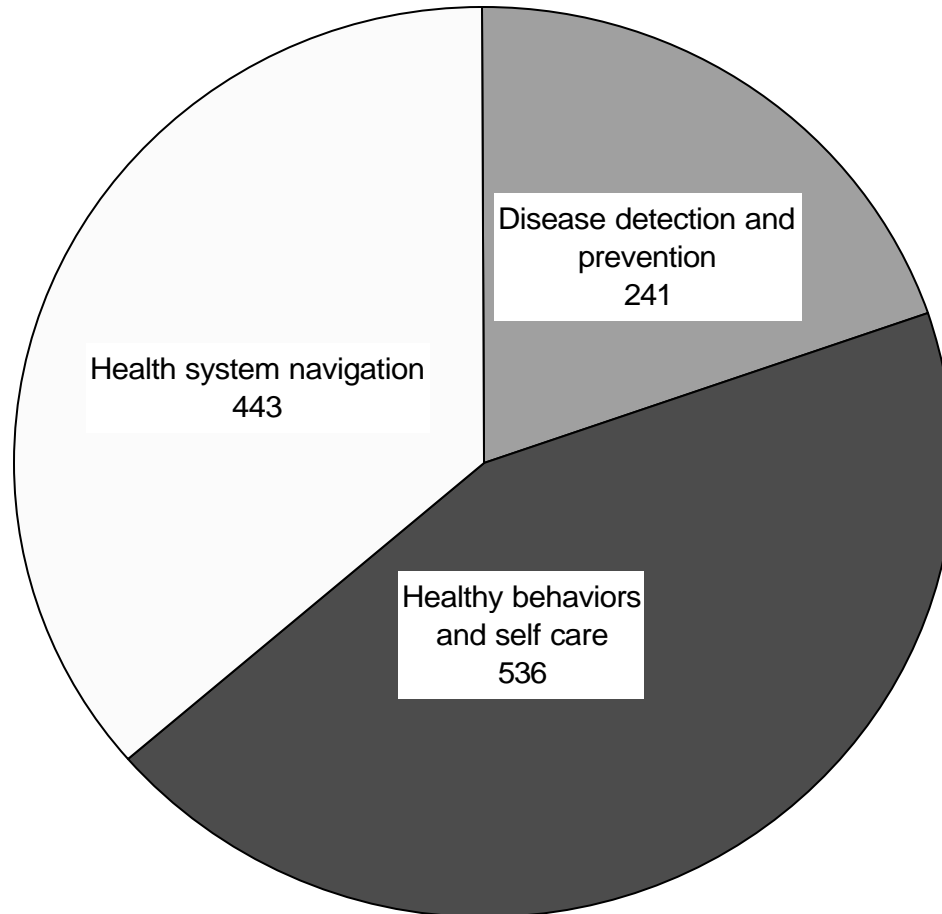
Health  
Education

Technology

*At Less Cost* by



## ***Better Health* through education about how to take charge**



**1,220 Clients  
Received Health  
Related Education  
since 12/02**

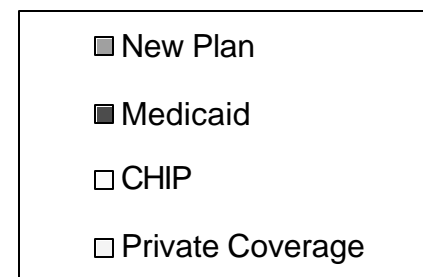
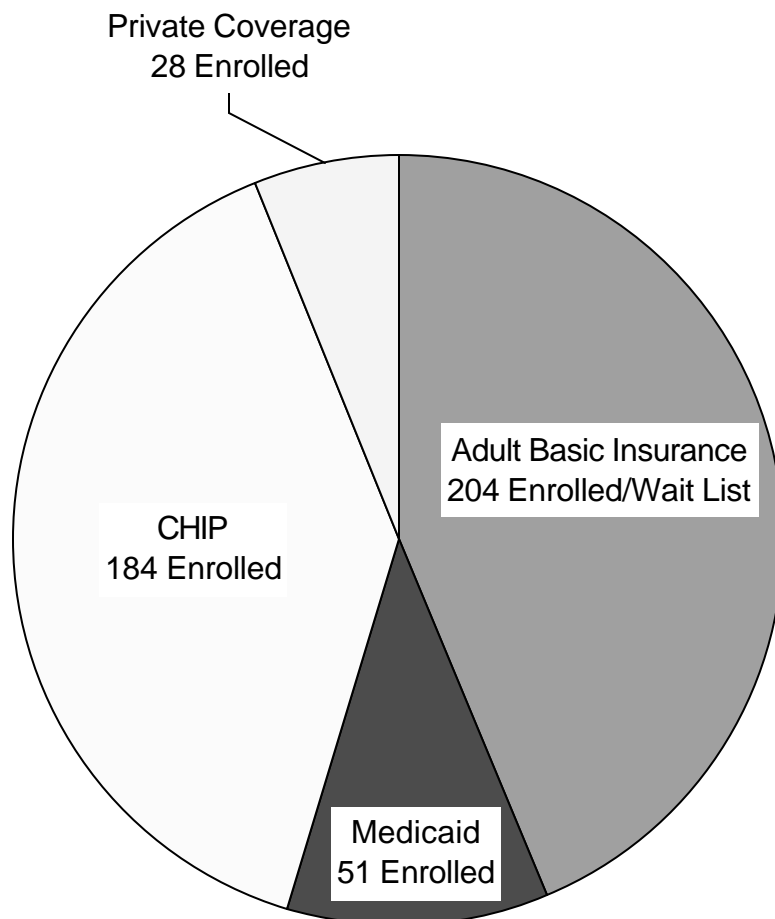
**An additional 3,784  
people were educated  
through community  
outreach efforts**

**Savings = \$ 402,000  
in reduced  
hospitalizations by  
teaching self care**

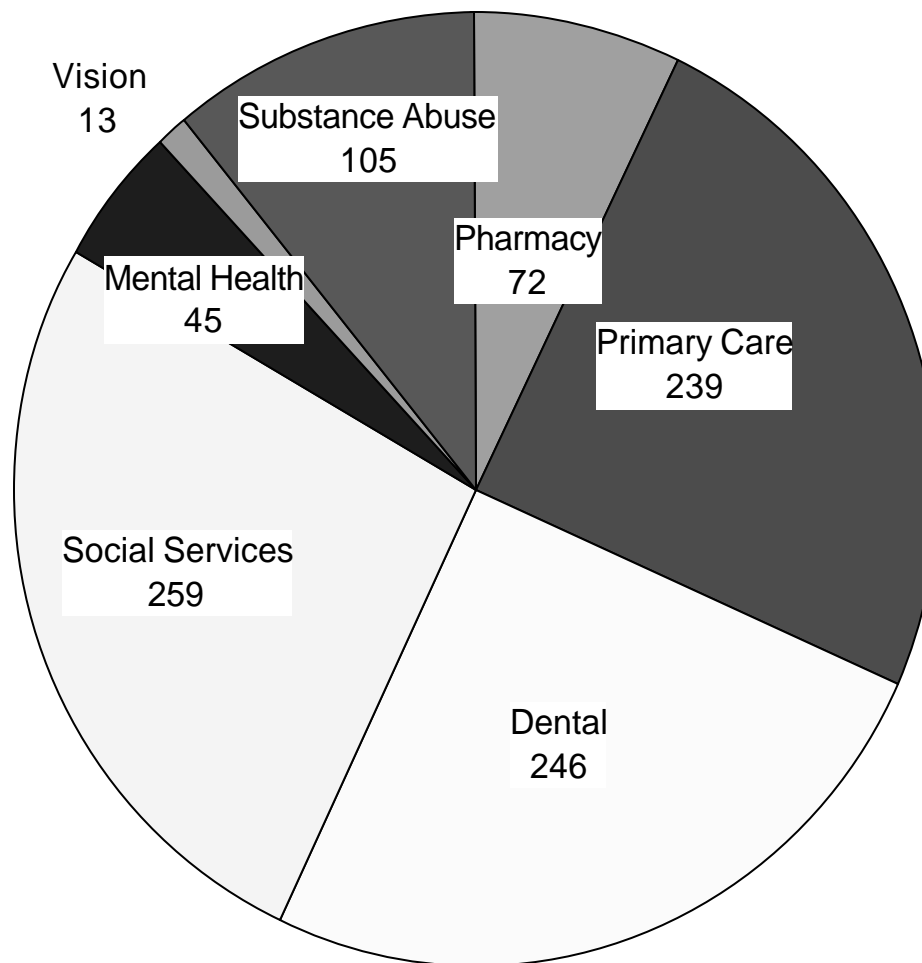
## Better Health through affordable coverage

**467 uninsured  
enrolled in affordable  
coverage since 12/02**

**Annual earnings  
increase when client  
obtains coverage  
and health status  
improves  
Value = \$1,157,243**



## ***At Less Cost* by reducing fragmentation**



**979 clients received facilitated referrals to necessary services since 12/02**

**76 clients needed interpreter services -Spanish language**

**Savings by having coordinated system of care vs. uncoordinated  
\$1.07 million**

# Reinvestment in the Community



- Increased Collaboration.
- Increased Enrollment - CHIP, Medicaid, etc.
- Coordinated availability of information on the care to underserved populations.
- Coordinated management of care and prevention services.
- Decreased utilization of inappropriate resources.
- A healthier community.



For additional information visit

**[www.healthyneaccess.org](http://www.healthyneaccess.org)**

or

**[www.scrantonrtg.com](http://www.scrantonrtg.com)**



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